Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Bath and North East Somerset Health Protection Board

Terms of Reference

Reporting to:	Bath and North East Somerset Health and Wellbeing Board
Health Protection Group authorised by:	Bath and North East Somerset Health and Wellbeing Board
Responsible Directorate:	Public Health Directorate, Bath and North East Somerset Council (B&NES)
Approval date of TOR:	June 2014
Review date of TOR:	Dec (6 month review)

Document history (author)

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Draft version (comments incorporated prior to first meeting of HP Board) JG	October 29th 2013
Draft version 2 (comments included from Nov 4th HP Board and subsequent formatting and collating some functions listed in section 2) BR, JG	Dec 12th 2013 and Feb 13th 2014
Draft version (BR) Amends made following changes agreed at previous Board meeting	Jun 9th 2014

1. Purpose

From April 2013 the Health and Social Care Regulations change the statutory responsibility for health protection arrangements. Upper tier and unitary local authorities acquired new responsibilities with regard to protecting the health of their population. Specifically local authorities are required, via their Directors of Public Health (DPH), to assure themselves that relevant organisations have appropriate plans in place to protect the population against a range of threats and hazards and to ensure that necessary action is being taken.

Following the introduction of multiple new NHS commissioning organisations and agencies involved in health protection, it is necessary to have one Board with the responsibility for coordinating the health protection responsibilities of those bodies locally. Thus threats to local health in Bath and North East Somerset (B&NES) should be minimised and dealt with promptly. This responsibility will be with the Health Protection Board, whose membership consists of commissioners, regulators and other organisations as described below.

The Board will take a system-wide overview of organisations and other stakeholders contributing to health protection in B&NEs and provide a whole system overview.
The purpose of the Health Protection Board would be to provide assurance, to B&NES local authority and the Health and Wellbeing Board, in regard to the adequacy of prevention, surveillance, planning and response with regard to the health protection issues that affect B&NES residents. It would also provide a route should there be specific health protection concerns, from a variety of stakeholders.

a. The purpose of the Health Protection Board is to ensure co-ordinated action across all sectors to protect the health of the people of B&NES from health threats, including major emergencies.
b. It supports the Director of Public Health (DPH) to carry out statutory responsibility to protect the health of the community through effective leadership and coordination, ensuring appropriate capacity and capability to detect, prevent and respond to threats to public health and safety.
c. The Health Protection Board will provide strategic direction and assurance on matters relating to health protection policy, risks and incidents.
d. All agencies will work collaboratively to exchange information and share knowledge and work together for the purpose of protecting the public's health.

2. Functions

a. To provide a forum for professional discussion of health protection plans, risks and opportunities for joint action
b. To ensure that effective arrangements are in place and are implemented, to protect B&NES people, whether resident, working or visiting B&NES.
c. To ensure effective health protection surveillance information is obtained, assessed and used appropriately so that appropriate action can be taken where necessary.

d. To ensure that public health threats requiring local intervention are identified, analysed and prioritised for action to protect public health.
e. To ensure that systems are in place for cascading major health protection concerns outside of this meeting.
f. To ensure that health threats are prevented through implementation of relevant local and national guidance and regulations to protect public's health.
g. To ensure that appropriate plans and policies exist to coordinate responses to public health activities, emergencies and threats in relation to the scope identified in section 4.
h. To ensure appropriate response to environmental hazards and control, biological, chemical, radiological and nuclear, including air and water quality, food safety, contaminated land incidences.
i. To agree relevant risks and performance measures that will be overseen by the Board.
j. To ensure appropriate governance for all health protection activities and programmes.
k. To establish local health protection assurance system and support organisations to deliver against the health protection outcomes (part of public health outcomes framework).
l. To receive reports that demonstrate compliance with, and progress against, health protection outcomes.
m. To ensure appropriate response to service challenges, major incidents and outbreaks – although the Board would only need to be alerted to serious incidents, such as mismanagement of a programme, closure of a ward due/MRSA.
n. To provide health protection (including emergency preparedness, resilience and response (EPRR)) assurance on regular (to be determined) basis to B&NES Health and Wellbeing Board and any other relevant local bodies via the Director of Public Health.
o. To ensure strong relationships between all agencies are maintained and developed to provide a robust health protection function in B&NES.
p. To quality-assure and risk-assure health protection plans on behalf of the local authority[i] and provide recommendations regarding the strategic and operational management of these risks.
q. To ensure health protection intelligence is integrated into the Joint Strategic Needs Assessments e.g. individual reports and annual report.
r. To enable / ensure systems are fit for purpose in achieving the desired outcomes, especially in managing the interdependencies between organisations and programmes.
s. To manage emerging health protection risks in delivering effective commissioning and provision of health and social care.
t. Reporting progress and forward planning:
    - To review quarterly performance monitoring against agreed outcomes and standards
    - To identify risk and mitigation of those risks in review of progress and action to be taken. Escalate to the Health & Wellbeing Board, as appropriate.

- To produce an annual report for the Health & Wellbeing Board
- To produce an annual work programme to ensure effective health protection risk review

Relation to other areas for cross-boundary issues

Relationships are in place with other areas for cross-boundary issues. Areas that do not have Health Protection Boards will be developing structures that can be linked in the future if required.

3. Accountability

a. The Health Protection Board will report to B&NES Health and Wellbeing Board (HWBB).
b. The DPH is accountable to the Chief Executive of B&NES Council for discharging health protection duties of the local authority.

4. Scope

The scope of the Health Protection Board is to minimise hazards to human health, and to ensure that any threats are promptly dealt with. Geographically, the scope covers the population of B&NES resident and non-residents who visit (links will be established with professionals in other areas as appropriate). Thematically, the scope covers the following health protection areas in the Health Protection Assurance Framework for B&NES:

a. Vaccination & immunisations
b. Infection prevention and control (IPC) related to healthcare associated infections
c. Alcohol, drugs and substance misuse
d. National screening programmes
e. Sexual health
f. Communicable disease control including TB, blood-borne viruses, gastro-intestinal (GI) infections, seasonal and pandemic influenza
g. Emergency preparedness, resilience and response
h. Public health advice regarding the planning for and control of pollution
i. Sustainable environment
j. Environmental hazards and control, biological, chemical, radiological and nuclear, including air and water quality, food safety, contaminated land
k. New and emerging infections, including zoonoses but not animal health

The scope of the Board would not be limited to those mentioned above.

It is anticipated that each of the health protection programme areas is likely to have its own programme board, already, but this may not be the case in all areas. These programme boards will be monitoring the commissioned services and performance managing the providers, as well as dealing with challenges and risks that arise. It is anticipated that the

chair or other representative from those boards would attend the Health Protection Board as part of the assurance process.

5. Strategic Linkages: to receive minutes and/or update from relevant committees/groups

a. Local Health Resilience Partnership
b. Joint Commissioning Group: for drugs and substance misuse in relation to hepatitis and HIV/AIDS
c. Public Health England: for surveillance data and outbreak control
d. Infection Control Collaborative meeting on relation to infection prevention and control re health care associated infections
e. Local Strategic Committee for Vaccination and Immunisation (this is not been formed yet but is being considered)
f. NHS England: Local Screening Committees
g. Environmental Health Liaison group
h. Seasonal flu planning
i. Sexual Health Programme Board
j. Any other groups whose work remits are linked to the health protection assurance framework.

6. Membership of Health Protection Group

a. DPH/Public Health Consultant Health Protection lead - (Chair)
b. B&NES Council Cabinet Member for Wellbeing
c. Public Health England: Health Protection - Consultant in Communicable Disease, or their representative
d. Area Team Head of Public Health Commissioning or their representative
e. Area Team Consultant for Screening and Immunisation or their representative
f. Area Team Director of Operations and Delivery who is Deputy Co- Chair Local Resilience Forum, or their representative
g. Emergency Planning Officers Group in B&NES: Emergency Planning lead
h. Environmental Health lead for Air and Water Quality and Food or their representative
i. CCG Director of Nursing and Quality (Director of Infection Prevention and Control-DIPC)
j. Representative from Substance Misuse Joint Commissioning Group
k. Representative from Sexual Health Programme Board
l. Representative from other groups/programme areas, where needed, to make sure all areas of risk represented
m. Representative from health and wellbeing board – a committee member not the chair

It is expected that core members will attend all meetings and representation will be from

the appropriate senior level. Where they cannot, an appropriately competent deputy, with the relevant skills and delegated authority, should attend in their place. Attendance of core members to board meetings will be monitored and reported in the annual reports of the Board.
7. Co-option of members
Other Leads of health protection elements maybe co-opted as and when appropriate.

8. Declarations of Interest
If any member had an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and shall not participate in the discussion. The Chair will have the power to request that member to withdraw until the Health Protection Board has given due consideration to the matter. All declarations of interest will be minuted.

9. Deputising
All members must make every effort to attend. If members are unable to attend they must send formal apologies, otherwise they will be recorded as 'did not attend'. Deputies should attend only when necessary.

10. Quorum
Chair or Deputy; and at least 3 other members from different agencies.

11. Frequency of meetings
3 monthly.

12. Agenda deadlines
Items to be received two weeks prior to meeting. Agenda to be circulated one week prior to meeting.

13. Minutes
Minutes will be circulated within two weeks of the meeting. Minutes will be circulated to all members of the Health Protection Board.

14. Urgent matters
Any urgent matters arising between meetings will be dealt with by Chair's action after agreement from three other members of the group.

15. Administration
Health Protection Manager and Secretarial support. Directorate of Public Health, B&NES.

16. Attendance
Members (or their nominated deputies) are required to attend a minimum of 3 out of 4 meetings annually.

17. TOR review
TOR will be reviewed at 12 months usually, but at 6 months in first 2 years.

References

DH (2012a) “The new public health role of local authorities”, Gateway reference 17876 published October 2012

Local Government Association, (2013) “Health and Wellbeing boards: a practical guide to governance and constitutional issues” published March 2013

DH (2012b) “ Health protection and local government” published Sept 2012, gateway reference 17740 (this document does not describe the final arrangements for health protection – as when it was produced national legislation had yet to be completed.)

DH, et al (2013) “Protecting the health of the local population: the new health protection duty of local authorities under the Local Authorities (Public Health functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013” May 2013, DH, PHE, LGA